State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

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The following ambulatory services are provided:

See Attachment 3.1-A, Item 2.c.

In addition to services covered in the remainder of Attachment 3.1-B, Special Food and Drug Administration (FDA) approved drug packages include the following:

Clozaril as approved by the US Food and Drug Administration is covered on an individual basis. Payment for Clozaril may be made via a global fee which consists of various medical components. These components include a dispensing fee, ingredient costs of the drug, drug administration, drawing of blood and case management/medical monitoring. Lab fee is to be billed separately.

Any limits ~~to~~ services provided in Attachment 3.1-B do not apply to individuals under EPSDT as long as medical necessity criteria as determined by OMS has been met.

Limitations in the State Plan may be exceeded with prior approval by the Office of Medical Services based on medical necessity.

*Description provided on attachment.

State/Territory: New Hampshire

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

Original

1. Inpatient hospital services other than those provided in an institution for mental diseases.

/X/Provided: /_/No limitations /X/With limitations*

2.a. Outpatient hospital services.

/X/Provided: /_/No limitations /X/With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

/X/Provided: /X/No limitations /_/With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

/X/Provided /_/No limitations /X/With limitations*

3. Other laboratory and X-ray services.

/X/ Provided: /_/ No limitations /X/With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

/X/Provided: /_/No limitations /X/With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

/X/Provided /_/No limitations /_/With limitations*

c. Family planning services and supplies for individuals of childbearing age.

/X/Provided: /_/No limitations /X/With limitations*

*Description provided on attachment.

State/Territory: NEW HAMPSHIRE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s):

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5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ___ No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations:

*Description provided on attachment.

1. Inpatient Hospital Services

Payment for inpatient hospital services is limited to medically necessary days only. Medically necessary days are days of stay approved by the State agency responsible for utilization review or its designee, i.e. the Professional Standards Review Organization (PSRO) which evaluates the quality, necessity and appropriateness of care and renders length of stay determinations.

All accommodations and ancillary services are paid for each approved medically necessary day. The day(s) of discharge do not count toward the limit. No payment is made for days of stay beyond the determination of medical necessity.

Coverage of organ transplantation is limited as per Attachment 3.1-E.

2. Outpatient Hospital Services

Payment for outpatient hospital services is limited to twelve (12) visits per recipient per fiscal year.

3. Other Laboratory and X-Ray Services

Payment is limited to fifteen (15) diagnostic x-ray procedures per recipient per fiscal year. This limit includes x-ray procedures when performed by a physician or an independent laboratory.

4a. Nursing Facility Services

Payment for nursing facility care is available to both categorically and medically needy recipients in need of such care. Payment for nursing facility care must be prior authorized for a specified period of time based on the amount and length of care recommended by the recipient's physician. Payment is made for a non-private room. Determination of need for nursing facility care and authorization of payment for nursing facility care is made by the Office of Long Term Care.

Medicaid-only certified beds in which nursing facility services are provided shall be at or about 5,146 beds statewide. However, the Department of Health and Human Services does not intend to attain this number of beds unless there is a need for the beds to ensure access to services. Furthermore, the Commissioner or his/her designee shall approve certification of additional Medicaid-only nursing facility beds if needed to ensure access to nursing facility services. *

Nursing facility beds certified for both Medicare and Medicaid will be approved in accordance with He-Hea 904.

4b. Early and Periodic Screening and Diagnosis

Limited to Federal requirements for the medically needy. Any limits to services provided in Attachment 3.1-B do not apply to individuals under EPSDT as long as medical necessity criteria as determined by the Medicaid Administration Bureau has been met.

4c. Family Planning Services

Payment for family planning services is subject to the limitations of each service category under which it falls. Family planning services provided by agencies under contract obligation with the Division of Public Health Services shall include education and counseling services.

* The legislature has mandated that funding be made available for appropriate and effective alternatives to nursing facility services. This can be accomplished by providing funding only for the number of nursing facility beds that are necessary to achieve the purpose of providing nursing facility services. The number of beds available to Medicaid eligibles is currently significantly greater than the number of beds occupied.

State/Territory: NEW HAMPSHIRE

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s): _____.

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5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: __No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: __No limitations X With limitations*

* Description provided on attachment.

State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Optometrists' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Chiropractors' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Other Practitioners' Services

/X/ Provided: /_/ No limitations /X/ With limitations*

7. Home Health Services

a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Home health aide services provided by a home health agency.

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

/X/ Provided: /_/ No limitations /X/ With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/X/ Provided: /_/ No limitations /X/ With limitations*

*Description provided on attachment.

6a. Podiatrists' Services

Payment for the services of podiatrists is limited to twelve (12) visits per recipient per fiscal year.

Podiatrist services shall be covered for medical and surgical treatments carried out below the ankle only, for pathological conditions of the foot. This includes trimming and burring of nails, including mycotic nails, and cutting, paring or removal of corns or calluses for recipients who are unable to do so provided that:

a. The recipient's attending physician shall have a written referral for these services; and

b. The referral shall be maintained in the recipient's record.

6b. Optometrists' Services

Payment for refraction is limited to one (1) per recipient per fiscal year whether the provider is an optometrist or ophthalmologist.

6c. Chiropractor's Services

Manual manipulation of the spine is the only service for which payment will be made. These services are limited to six (6) per recipient per fiscal year.

6d. Other Practitioners' Services

Clinical Psychologist

Treatment provided by a certified clinical psychologist, who is not on the staff of a community mental health center, is covered up to twelve (12) psychotherapy visits per recipient per state fiscal year. Such visits are to be counted toward the twelve (12) visit psychotherapy cap for all non-physician practitioners.

6d. Other Practitioner's Services

Advanced Registered Nurse Practitioners

Section 6405 of P.L. 101-239 (OBRA 1989) is met by ARNP. Treatment provided by advanced registered nurse practitioners who meet state requirements is covered up to eighteen (18) visits anywhere other than the inpatient hospital per recipient per fiscal year. Psychotherapy is covered up to twelve (12) visits per recipient per state fiscal year. Such psychotherapy visits are to be counted toward the twelve (12) visit psychotherapy cap for all non-physician practitioners.

Pastoral Counselors

Psychotherapy services provided by a licensed pastoral counselor, who is not on the staff of a community mental health center, is covered up to twelve (12) visits per recipient per state fiscal year. Such visits are to be counted toward the twelve (12) visit psychotherapy cap for all non-physician practitioners.

7. Home Health Services

a. & b. Nursing and Home Health Aide

Services can only ~~be~~ provided in the patient's place of residence, not in an institution.

7c. Medical Supplies, Equipment and Appliances

Prior authorization is required for the rental and repair of durable medical equipment; and purchases of medical equipment costing $100.00 or more with the following exceptions which do not require prior authorization: (1) purchase of orthopedic shoes and non-programmable hearing aids; (2) rental of oxygen systems; and (3) wheelchair repairs costing $800 or less.

Electric wheelchairs are paid for when prescribed by a physician with a specialty related to the condition for which the wheelchair is being prescribed. Recipients must be confined to a bed or wheelchair, unable to operate a manual wheelchair, and be able to independently operate an electric wheelchair. Purchase of electric wheelchairs is limited to one per recipient per every five years except for children under age 16 and/or for EPSDT purposes. Accessories and wheelchair modifications are limited to those prescribed by the physician.

7d. Physical and Occupational Therapy, Speech Pathology and Audiology Services

When provided by a home health agency, visiting nurse association or independent therapist, these services are limited to forty (40) units per recipient per state fiscal year. The forty (40) units may be used for one type of therapy or in any combination of therapies. Prior authorization from the Office of Medical Services is required when therapy services are prescribed over the service limit.

Services provided by a rehabilitation center are limited to twelve (12) visits per recipient per fiscal year for all types of service except therapies which are subject to the above limits.

State/Territory: New Hampshire

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All

8. Private duty nursing services.

/X/ Provided: /_/ No limitations /X/ With limitations*

9. Clinic services.

/X/ Provided: /_/ No limitations /X/ With limitations*

10. Dental services.

/X/ Provided: /_/ No limitations /X/ With limitations*

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Occupational therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

/X/ Provided: /_/ No limitations /X/ With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: /_/ No limitations /X/ With limitations*

b. Dentures.

/_/ Provided: NOT PROVIDED /_/ No limitations /_/ With limitations*

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

8. Private Duty Nursing Services

Private duty nursing services which are covered are those provided by a registered or licensed practical nurse under the order and general direction of the patient's physician to a patient only in his place of residence, not a long term care facility. Prior authorization is required every sixty (60) days from the Medicaid Administration Bureau.

9. Clinic Services

Out-of-state clinic services require prior authorization from the Medicaid Administration Bureau. Such payment authorization may be given only if substantiated by the attending physician's statement of medical necessity.

10. Dental Services

Treatment covered for recipients under 21 includes: (a) prophylaxis, (b) restorative treatment, (c) periodic examinations, no more frequently than every one hundred fifty days, unless they are medically necessary to determine the existence of a suspected illness or condition, (d) vital pulpotomy, (e) extractions, (f) general anesthesia, (g) orthodontic therapy, (h) x-rays, (i) palliative treatment, (j) prosthetic replacement of anterior permanent teeth, canine to canine, (k) topical fluoride treatment two times/year until age 13, (l) root canal, (m) sedative fillings, when necessary for emergency relief of pain, (n) crowns, (o) periodontic services, and (p) sealants every 5 years.

Dental services covered for recipients 21 and over for the treatment for relief of acute pain or elimination of acute infection are: (a) palliative treatment, (b) extraction of the causitive tooth or teeth, (c) treatment of severe trauma, (d) surgical procedures performed in a hospital, and (e) x-rays for areas described above.

Prior authorization from the Medicaid Administration Bureau is required for (a) orthodontic therapy, and (b) services not listed but identified in an EPSDT screening. Prior authorization for orthodontic therapy is granted based upon substantiation of the meeting of conditions specified by the Medicaid Administration Bureau. Orthodontic therapy includes 24 periodic visits which are covered only until the recipient reaches the age of 21.